TITLE 471
NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 1-000 ADMINISTRATION

1-001 Introduction: This title addresses services provided under the Nebraska Medical Assistance Program (also known as Nebraska Medicaid).

1-001.01 Legal Basis: The Nebraska Medical Assistance Program (NMAP) was established under Title XIX of the Social Security Act. The Nebraska Legislature established the program for Nebraska in Neb.Rev.Stat. §68-1018. NMAP is administered statewide by the Nebraska Department of Health and Human Services Finance and Support (HHS Finance and Support or the Department).

1-001.02 Purpose: The Nebraska Medical Assistance Program was established to provide medical and other health-related services to aged, blind, or disabled persons; dependent children; and any persons otherwise eligible who do not have sufficient income and resources to meet their medical needs.

1-001.03 Title XIX Plan: The State Plan for Title XIX of the Social Security Act - Medical Assistance Program is a comprehensive written commitment of the state to administer the Nebraska Medical Assistance Program in accordance with federal requirements. The Title XIX Plan is approved by the Federal Department of Health and Human Services. The approved plan is a basis for determining federal financial participation in the state program. The rules and regulations of NMAP implement the provisions of the Title XIX Plan.

1-002 Nebraska Medicaid-Coverable Services: The Nebraska Medical Assistance Program covers the following types of service, when medically necessary and appropriate, under the program guidelines and limitations for each service:

1. Inpatient hospital services;
2. Outpatient hospital services;
3. Rural health clinic services;
4. Federally qualified health center services;
5. Laboratory and x-ray services;
6. Nurse practitioner services;
7. Nursing facility (NF) services;
8. Home health services;
9. Early and periodic screening, diagnosis, and treatment (HEALTH CHECK);
10. Family planning services;
11. Physician services and medical and surgical services of a dentist;
12. Nurse midwife services;
13. Prescribed drugs;
14. Services in intermediate care facilities for the mentally retarded (ICF/MR);
15. Inpatient psychiatric services for individuals under age 21;

16. Inpatient psychiatric services for individuals age 65 and older in an institution for mental diseases;
17. Personal assistance services;
18. Clinic services;
19. Psychologist services;
20. Dental services and dentures;
21. Physical therapy services;
22. Speech pathology and audiology services;
23. Medical supplies and equipment;
24. Prosthetic and orthotic devices;
25. Optometric services;
26. Eyeglasses;
27. Private duty nursing services;
28. Podiatry services;
29. Chiropractic services;
30. Case management services;
31. Medical transportation, including ambulance services;
32. Occupational therapy services;
33. Emergency hospital services;
34. Screening services (mammograms); and
35. Home and community-based waiver services (see Title 480 NAC).

(Certain services covered under the home and community-based waivers may not meet the general definition of "medical necessity" and are covered under the NMAP.)

1-002.01 Nebraska Medicaid Managed Care Program: Certain Medicaid clients are required to participate in the Nebraska Medicaid Managed Care Program also known as the Nebraska Health Connection (NHC). The Department developed NHC to improve the health and wellness of Nebraska's Medicaid clients by increasing their access to comprehensive health services in a way that is cost effective to the State. Enrollment in NHC is mandatory for certain clients in designated geographic areas of the state. The client's participation in NHC will be indicated on the client's NHC ID Document. NHC clients will not receive the Nebraska Medicaid Card. Participation in NHC can also be verified by contacting the Nebraska Medicaid Eligibility System (NMES) (see 471-000-124) or using the standard electronic Health Care Benefit Inquiry and Response transaction (ASC X12N 270/271) (see Standard Electronic Transaction Instructions at 471-000-50).

NHC utilizes two models of managed care plans to provide the basic benefits (medical/surgical) package; these models are health maintenance organizations (HMO's) and primary care case management (PCCM) networks. NHC also provides a mental health and substance abuse services (MH/SA) benefits package that is available statewide to all clients who are required to participate in NHC. See 471-000-122 for a list of NHC's plans.

Services included in the benefits package that are provided to a client who is participating in NHC must be coordinated with the plan. The requirements for provision of services in the NHC benefits package are included in the appropriate Chapters of this Title. Services that are not included in the benefits package will be subject to all requirements of this Title.

For clients enrolled in an NHC plan for the basic benefits package, copayments are required only for prescription drugs. Clients enrolled only in the NHC mental health/substance abuse plan are subject to copayments required under 471 NAC 3-008 ff.

1-002.02 Limitations and Requirements for Certain Services

1-002.02A Medical Necessity: NMAP applies the following definition of medical necessity:

Health care services and supplies which are medically appropriate and -

1. Necessary to meet the basic health needs of the client;
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
3. Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;
4. Consistent with the diagnosis of the condition;
5. Required for means other than convenience of the client or his or her physician;
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
7. Of demonstrated value; and
8. No more intense level of service than can be safely provided.

The fact that the physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or mental illness does not mean that it is covered by Medicaid. Services and supplies which do not meet the definition of medical necessity set out above are not covered.

Approval by the federal Food and Drug Administration (FDA) or similar approval does not guarantee coverage by NMAP. Licensure/certification of a particular provider type does not guarantee NMAP coverage.

1-002.02B Place of Service: Covered services must be provided at the least expensive appropriate place of service. Payment for services provided at alternate places of service may be reduced to the amount payable at the least expensive appropriate place of service, or denied, as determined by the appropriate staff of the Medicaid Division.

1-002.02C Experimental or Investigational Services: NMAP does not cover medical services which are considered investigational and/or experimental or which are not generally employed by the medical profession. While the circumstances leading to participation in an experimental or investigational program may meet the definition of medical necessity, NMAP prohibits payment for these services.

Within this part, medical services include, but are not limited to, medical, surgical, diagnostic, mental health, substance abuse, or other health care technologies, supplies, treatments, procedures, drugs, therapies, and devices.

1-002.02C1 Related Services: NMAP does not pay for associated or adjunctive services that are directly related to non-covered experimental/investigational services (for example, laboratory services, radiological services, other diagnostic or treatment services, practitioner services, hospital services, etc.).

NMAP may cover complications of non-covered services once the non-covered service is completed (see 471 NAC 1-002.02L).

1-002.02C2 Requests for NMAP Coverage: Requests for NMAP coverage for new services or those which may be considered experimental or investigational must be submitted before providing the services, or in the case of true medical emergencies, before submitting a claim. Requests for NMAP determinations for such coverage must be submitted in writing to the NMAP Medical Director at the following address by mail or fax method:

Medical Director
Nebraska Department of Health and Human Services Finance and Support
Medicaid Division
P.O. Box 95026
Lincoln, NE 68509-5026
Fax Phone Number: (402) 471-9092

The request for coverage must include sufficient information to document that the new service is not considered investigational/experimental for Medicaid payment purposes. Reliable evidence must be submitted identifying the status with regard to the criteria below, cost-benefit data, short and long term outcome data, patient selection criteria that is both disease/condition specific and age specific, information outlining under what circumstances the service is considered the accepted standard of care, and any other information that would be helpful to the Department in deciding coverage issues. Additional information may be requested by the Medical Director.

Services are deemed investigational/experimental by the Medical Director, who may convene ad hoc advisory groups of experts to review requests for coverage. A service is deemed investigational/experimental if it meets any one of the following criteria:

1. There is no Food and Drug Administration (FDA) or other governmental/regulatory approval given, when appropriate, for general marketing to the public for the proposed use;

2. Reliable evidence does not permit a conclusion based on consensus that the service is a generally accepted standard of care employed by the medical profession as a safe and effective service for treating or diagnosing the condition or illness for which its use is proposed. Reliable evidence includes peer reviewed literature with statistically significant data regarding the service for the specific disease/proposed use and age group. Also, facility specific data, including short and long term outcomes, must be submitted to the Department;
3. The service is available only through an Institutional Review Board (IRB) research protocol for the proposed use or subject to such an IRB process; or
4. The service is the subject of an ongoing clinical trial(s) that meets the definition of a Phase I, Phase II, or Phase III Clinical Trial, regardless of whether the trial is actually subject to FDA oversight and regardless of whether an IRB process/protocol is required at any one particular institution.

1-002.02C3 Definition of Clinical Trials: For services not subject to FDA approval, the following definitions apply:

Phase I: Initial introduction of an investigational service into humans.

Phase II: Controlled clinical studies conducted to evaluate the effectiveness of the service for a particular indication or medical condition of the patient; these studies are also designed to determine the short-term side effects and risks associated with the new service.

Phase III: Clinical studies to further evaluate the effectiveness and safety of a service that is needed to evaluate the overall risk/benefit and to provide an adequate basis for determining patient selection criteria for the service as the recommended standard of care. These studies usually compare the new service to the current recommended standard of care.

1-002.02D Cosmetic and Reconstructive Surgery: NMAP limits reimbursement for cosmetic and reconstructive surgical procedures and medical services that are performed when medically necessary for the purpose of correcting the following conditions:

1. Limitations in movement of a body part caused by trauma or congenital conditions;
2. Painful scars/disfiguring scars in areas that are visible;
3. Congenital birth anomalies;
4. Post-mastectomy breast reconstruction; and
5. Other procedures determined to be restorative or necessary to correct a medical condition.

1-002.02D1 Exceptions: To determine the medical necessity of the condition, the Department requires prior authorization for cosmetic and reconstructive surgical procedures, except for the following conditions:

1. Cleft lip and cleft palate;
2. Post-mastectomy breast reconstruction;
3. Congenital hemangioma's of the face; and
4. Nevus (mole) removals.

1-002.02D2 Cosmetic and Reconstructive Prior Authorization Procedures: In addition to the prior authorization requirements under 471 NAC 18-004.01, the surgeon who will be performing the cosmetic or reconstructive (C/R) surgery shall submit a request to the Medical Director. This request must include the following:

1. An overview of the medical condition and medical history of any conditions caused or aggravated by the condition;
2. Photographs of the involved area(s) when appropriate to the request;
3. A description of the procedure being requested including any plan to perform the procedure when it requires a staged process; and
4. When appropriate, additional information regarding the medical history may be submitted by the client's primary care physician.

Prior authorization request for cosmetic and reconstructive surgery must be submitted using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transaction Instructions at 471-000-50) or in writing by mail or fax to the following address:

Medical Director
Nebraska Department of Health and Human Services Finance and Support
Medicaid Division
P.O. Box 95026
Lincoln, NE 68509-5026

Fax Telephone Number: (402) 471-9092

1-002.02E Preventive Health Care: To ensure early detection and treatment, to maintain good health, and to ensure normal development, NMAP provides the HEALTH CHECK program to clients age 20 and younger. HEALTH CHECK is a program of early and periodic screening, diagnosis, and treatment (EPSDT) designed to combine the health services of screening, diagnosis, and treatment with outreach, supportive services, and follow-up to promote and provide preventive health care. See 471 NAC 33-000.

Other preventive health care services covered by NMAP are listed in the individual provider chapters.

1-002.02F Family Planning Services: NMAP covers family planning services, including consultation and procedures, when requested by the client. Family planning services and information must be provided to clients without regard to age, sex, or marital status, and must include medical, social, and educational services. The client must be allowed to exercise freedom of choice in choosing a method of family planning. Family planning services performed in family planning clinics must be prescribed by a physician, and furnished, directed, or supervised by a physician or registered nurse.

Covered services for family planning include initial physical examination and health history, annual and follow-up visits, laboratory services, prescribing and supplying contraceptive supplies and devices, counseling services, and prescribing medication for specific treatment.

1-002.02G Services Provided Outside Nebraska: Payment may be approved for services provided outside Nebraska in the following situations:

1. When an emergency arises from accident or sudden illness while a client is visiting in another state and the client's health would be endangered if medical care is postponed until s/he returned to Nebraska;
2. When a client customarily obtains a medically necessary service in another state because the service is more accessible;
3. When the client requires a medically necessary service that is not available in Nebraska; and
4. When the client requires a medically necessary nursing facility (see 471 NAC 12-014.04) or ICF/MR (see 471 NAC 31-003.05) service not available in Nebraska.

1-002.02G1 Prior Authorization Requirements: Prior authorization is required for services provided outside Nebraska when -

1. The service is not available in Nebraska (see 471 NAC 1-002.02G, items 3 and 4); or
2. The service requires prior authorization under the individual chapters of this Title.

1-002.02G2 Prior Authorization Procedures for Out-of-State Services: The referring physician shall submit a request to the Department using the standard electronic Health Care Services Review Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transaction Instructions at 471-000-50) or by mail or fax to the following address:

Medical Director
Nebraska Department of Health and Human Services Finance and Support
Medicaid Division
P.O. Box 95026
Lincoln, NE 68509-5026

Fax telephone number: (402) 471-9092

For prior authorization procedure for nursing facility services, see 471 NAC 12-014.04. For prior authorization procedures for ICF/MR services, see 471 NAC 31-000.

The request must include the following information or explanation as appropriate to the case:

1. A summary of the client's physician's evaluation of the client and the determination that the service is not available in Nebraska, or if available, the service is not adequate to meet the client's needs;
2. The name, address, and telephone number of the out-of-state provider;
3. An indication of whether the out-of-state provider is enrolled or is willing to enroll as a Nebraska Medicaid provider and accept the Medicaid allowable payment as payment in full for the services;
4. A description of the client's condition. The physician must certify, based on a thorough evaluation, that the services being requested are medically necessary and not experimental or investigational;
5. Identification of the physician who will be assuming follow-up care when the client returns to Nebraska;
6. Any plan for follow-up and return visits, including a timeline for the visits (for example, annually, every six months, as needed), and an explanation of the medically necessity for the return visits;
7. If the client is requesting assistance with transportation, the type of transportation appropriate for the client's condition, and when ambulance, air ambulance, or commercial air transportation is being requested, the request must provide an explanation of medical necessity; and
8. The client's name, address, and Medicaid recipient identification number, or date of birth.

1-002.02H Sales Tax: The State of Nebraska is tax-exempt; therefore, providers shall not charge sales tax on claims to the Department or NMAP. Sales tax may be an appropriate inclusion on cost reports.

1-002.02J Services Not Directly Provided For Treatment or Diagnosis: NMAP does not cover services provided to a client that are not directly related to diagnosis or treatment of the client's condition (for example, blood drawn from a client to perform chromosome studies because a relative has had problem pregnancies, paternity testing, research studies, etc.). Exception: For transplant-donor-related services, see 471 NAC 10-005.20 and 18-004.40.

1-002.02J1 Autopsies: NMAP does not pay for autopsies.

1-002.02K Services to the Ineligible Mother of an Eligible Unborn Child: NMAP covers services for the ineligible mother of an eligible unborn child under the following conditions:

1-002.02K1 Covered Individuals: Individuals covered under this Medicaid-defined category include those women whose Nebraska Medicaid Card, NHC ID Document, the Nebraska Medicaid Eligibility System (NMES), or the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) indicates eligibility for the unborn/newborn but not for the mother. A woman with this type of eligibility status is only eligible for the services defined under this section.

1-002.02K2 Eligibility Limitation: This Medicaid coverage ends on the last day of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

1-002.02K3 Covered Services: Under this benefit, NMAP covers the following services:

1. Pregnancy-Related Services: Services for the treatment of conditions or complications that exist or are exacerbated because of pregnancy. This includes, for example, -
   a. Medical services to treat a threatened miscarriage or premature delivery;
   b. Treatment of condition or complications that exist or are exacerbated because of pregnancy (such as diabetes, hypertension, epilepsy, preeclampsia, eclampsia, postpartum depression, cholelithiasis, cholecystectomy, etc.);
   c. Treatment of sexually transmitted diseases;
   d. Services required to treat an accident or illness that occurred before delivery;
   e. Medically necessary services to ensure a healthy maternal outcome and a healthy outcome for the current pregnancy and the unborn child. NMAP also covers associated services during pregnancy and around the time of delivery to ensure a healthy maternal outcome. This includes, but is not limited to, services such as dilation and curettage to treat complications of pregnancy, such as miscarriage or retained placenta; tubal ligations, and gynecological surgery, such as gynecological tumor removal, etc.;
   f. Medical services to treat complications in the postpartum period; and
   g. Home health services for pregnancy-related services;

   Note: For risk reduction services for HEALTH CHECK participants, see 471 NAC 33-003.02.
2. Prenatal Services: Services to a woman during pregnancy which are directed to protecting and ensuring the health of the woman and the unborn child.
3. Delivery Services: Services necessary to protect the health and safety of the woman and unborn child from the onset of labor through delivery.
4. Postpartum Services: Services provided to a woman following termination of pregnancy for any health conditions or complications that are pregnancy-related. Note: Medicaid funding is not available for postpartum services related to induced abortions that are not covered by Medicaid.

5. Family Planning Services: See 471 NAC 1-002.02F, including tubal ligations.
6. Drugs: Those drug products prescribed during pregnancy (through the postpartum period) when necessary for treatment of existing and pre-existing conditions which affect the health of the mother or the unborn child. NMAP covers drug products prescribed during the postpartum period for new conditions directly related to the pregnancy, delivery, and family planning.

1-002.02L Services Required to Treat Complications or Conditions Resulting from Non-Covered Services: NMAP may consider payment for medically necessary services that are required to treat complications or conditions resulting from non-covered services.

Medical inpatient or outpatient hospital services are sometimes required to treat a condition that arises from services which NMAP does not cover. Payment may be made for services furnished under these circumstances if they are reasonable and necessary and meet NMAP requirements in 471 NAC.

Examples of services that may be covered under this policy include, but are not limited to -

1. Complications/conditions occurring following cosmetic/reconstructive surgery not previously authorized by NMAP (for example, breast augmentation, liposuction);
2. Complications from a non-covered medical transplant or a transplant that has not been previously authorized by NMAP;
3. Complications/conditions occurring following an abortion not previously authorized by NMAP; or
4. Complications/conditions occurring following ear piercing.

If the services in question are determined to be part of a previous non-covered service, i.e., an extension or a periodic segment of a non-covered service or follow-up care associated with it, the subsequent services will be denied. For example, when a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's prognosis, these visits are not covered.

1-002.02M Drug Rebates

1-002.02M1 Legal Basis: These regulations govern the Drug Rebate Program, established by Section 1927 of the Social Security Act, attached and incorporated by reference. The definitions and terms in Section 1927 of the Social Security Act apply to these regulations.

The Nebraska Medical Assistance Program, also known as Nebraska Medicaid, covers prescribed drugs only if the labeler has signed a Rebate Participation Agreement with the Secretary of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Coverage of prescribed drugs is subject to 471 NAC 16-000, Pharmacy Services.

1-002.02M2 Rebate Dispute Resolution: If, in any quarter, a manufacturer discovers a discrepancy in Medicaid utilization information that the manufacturer and the Department are unable to resolve in good faith, the manufacturer must provide written notice of the discrepancy by National Drug Code (NDC) number to the Department within 30 days after receiving the Medicaid utilization information.

If the manufacturer, in good faith, believes that the Medicaid utilization information is erroneous, the manufacturer must pay the Department that portion of the rebate amount claimed that is not disputed within 30 days after receiving the Medicaid utilization information. The balance due, if any, plus a reasonable rate of interest as set forth in Section 1903(d)(5) of the Social Security Act must be paid or credited by the manufacturer or by the Department by the due date of the next quarterly payment after resolution of the dispute.

The Department and the manufacturer must use their best efforts to resolve the discrepancy within 60 days of receipt of notification. If the Department and the manufacturer are not able to resolve a discrepancy within 60 days, CMS requires the Department to make available to the manufacturer the Department's administrative hearing process under 465 NAC 6.

The hearing decision is not binding on the Secretary of Health and Human Services, CMS, for purposes of his/her authority to implement a civil money penalty provision of the statute or the rebate agreement.

Nothing in this section precludes the right of the manufacturer to audit the Medicaid utilization information reported or required to be reported by the Department.

Adjustments to rebate payments must be made if information indicates that either Medicaid utilization information, average manufacturer price (AMP), or best price is greater or less than the amount previously specified.

1-002.02M3 Manufacturer Right to Appeal: Every manufacturer of a rebatable drug that has a signed rebate agreement has the limited right to appeal to the Director of Finance and Support for a hearing. This appeal right is limited to any discrepancies in the quarterly Medicaid utilization information only. No other matter relating to that manufacturer's drugs may be appealed to the Director, including but not limited to the drug's coverage status, prior authorization status, estimated acquisition cost, state maximum allowable cost, or allowable quantity. A manufacturer must request a hearing within 90 days of the date the Department gives notice to the manufacturer of the availability of the hearing process for the disputed drugs.

1-002.02M4 Filing a Request: If the manufacturer wishes to appeal an action of the Department, the manufacturer must submit a written request for a hearing to the Director of Finance and Support. The manufacturer must identify the basis of the appeal in the request.

1-002.02M5 Scheduling a Hearing: When the Director receives a request for hearing, the request is acknowledged by a letter which states the time and date of the hearing.

1-002.02M6 Hearings: Hearings are scheduled and conducted according to 465 NAC 6-000, Practice and Procedure for Hearings in Contested Cases Before the Department.

1-002.02N Requirements for Written Prescriptions: The Nebraska Medical Assistance Program will not pay for written prescriptions for prescribed drugs unless executed on a tamper-resistant pad as required by federal law. This includes written prescriptions:

1. For otherwise covered prescription-only and over-the-counter drugs.
2. When Medicaid is the primary or secondary payer.
3. For drugs provided in Nursing Facilities, ICF/MR facilities, and other specified institutional and clinical settings (inpatient and outpatient hospital, hospice, dental, laboratory, x-ray and renal dialysis) when the drug is separately reimbursed.

1-002.02N1 Exclusions: The following prescriptions and other items are not required to be written on tamper-resistant prescription pads:

1. Orders for drugs provided in Nursing Facilities, ICF/MR facilities, and other specified institutional and clinical settings (inpatient and outpatient hospital, hospice, dental, laboratory, x-ray and renal dialysis) for which the drug is not separately reimbursed, but is reimbursed as part of a total service;
2. Refills of written prescriptions that are presented at a pharmacy before April 1, 2008;
3. Faxed prescriptions;
4. Telephoned, or otherwise orally transmitted prescriptions;
5. E-prescribing, when the prescription is transmitted electronically;
6. Prescriptions for Medicaid recipients that are paid entirely by a managed care entity; and
7. Co-pays covered by DHHS funds for prescriptions for drugs covered by Medicare Part D, for certain dual eligible persons.

1-002.02N2 Effective April 1, 2008, a written Medicaid prescription must contain at least one of the following characteristics:

1. An industry-recognized feature designed to prevent unauthorized copying of a completed or blank prescription form, such as a high security watermark on the reverse side of the blank or thermochromic ink;
2. An industry-recognized feature designed to prevent erasure or modification of information written on the prescription by the prescriber, such as tamper-resistant background ink that shows erasures or attempts to change written information; or
3. An industry-recognized feature designed to prevent the use of counterfeit prescription forms, such as sequentially numbered blanks or duplicate or triplicate blanks.

1-002.02N3 Effective October 1, 2008, a written Medicaid prescription must contain all three characteristics listed in 471 NAC 1-002.02N2.

1-002.02N4 Emergency Fills: NMAP will pay for emergency fills for prescriptions written on non-tamper resistant pads only when the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant paper. The pharmacy must document the call on the face of the written prescription.

1-003 Verifying Eligibility for Medical Assistance: Providers may verify the eligibility of a client by viewing the client's current Medicaid eligibility document (see 471-000-123 for examples). Clients participating in the Nebraska Medicaid Managed Care Program will have an NHC Identification Document (see 471-000-122). Eligibility may also be verified by contacting the Nebraska Medicaid Eligibility System (NMES) (see 471-000-124) or the client's local HHS office (see 471-000-125), or by using the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) (see Standard Electronic Transaction Instructions at 471-000-50).

When a client initially becomes eligible for medical assistance, s/he may not possess a Medicaid eligibility document until the following month. The provider shall verify the eligibility of the client(s) by contacting NMES or the local office or by using the standard electronic transaction (ASC X12N 270/271).

1-004 Federal and State Requirements: The Department is required by federal and state law to meet certain provisions in the administration of the Nebraska Medical Assistance Program.

1-004.01 Medical Assistance Advisory Committee: The Director of the Department appoints an advisory committee to advise the Director in the development of health and medical care services policies. Members of the committee include physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care; members of consumers' groups, including NMAP clients; and consumer organizations, such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others; the Director of Regulation and Licensure and the Director of Health and Human Services. Members are appointed on a rotating basis to provide continuity of membership.

1-004.02 Free Choice of Providers: An NMAP client may obtain covered services from any provider qualified to perform the services who has been approved to participate in NMAP. The client's freedom of choice does not prevent the Department from -

1. Determining the amount, duration, and scope of services;
2. Setting reasonable and objective standards for provider participation; and
3. Establishing the fees which are paid to providers for covered services.

Clients participating in the Nebraska Medicaid Managed Care Program are required to access services through their primary care physician.

1-004.03 Utilization Review (UR): The Department or its designee perform utilization review activities related to the kind, amount, and frequency of services billed to NMAP to ensure that funds are spent only for medically necessary and appropriate services. The Department or its designee may request information from clients' records as part of the utilization review process. In the absence of specific NMAP state UR regulations, Medicare UR regulations may apply.

1-004.04 Transportation to Receive Medical Services: See 471 NAC 27-000. Transportation to receive medical services may be arranged for NMAP clients by staff who handle the Social Services Block Grant Program, if the client is eligible for the Social Services Block Grant or other designated agencies. Payment for transportation for medical services may be included as a special requirement in the budget for an AABD client.

1-005 Medicare Benefits (Title XVIII) Buy-In: The Department pays monthly premiums for Part B of Medicare only for clients who -

1. Are 65 years of age or older; or
2. Meet the eligibility requirements of disability in Nebraska's Assistance to the Aged, Blind, or Disabled Program.

See 471 NAC 3-004 for further information on Medicare/Medicaid crossover claims and Medicare managed care plans.

1-006 TELEHEALTH SERVICES

1-006.01 Scope and Authority: These regulations govern Medicaid covered telehealth services and implement the Nebraska Telehealth Act (Neb. Rev. Stat. Sections 71-8501 to 8508). This statute authorizes the Department to cover telehealth consultations and transmission costs.

Under the Act telehealth consultation means any contact between a patient and a health care practitioner relating to the health care diagnosis or treatment of such patient through telehealth but does not include a telephone conversation, electronic mail message, or facsimile transmission between a health care practitioner and a patient or a consultation between two health care practitioners. “Consultation” elsewhere in the Nebraska Medical Assistance Program (NMAP) regulations refers to services provided by a physician specialist. Therefore, for purposes of these NMAP regulations, “telehealth service” is used instead of “telehealth consultation” to clarify that coverage is available beyond the traditional meaning of “consultation”.

Medicaid coverage for telehealth services allows clients, particularly those in medically underserved areas of the state, to improve access to essential health care services that may not otherwise be available without traveling long distances.

1-006.02 Definitions:

Electronic Mail (e-mail) Transmission means transactions of a text or graphical nature between two or more persons exchanged by e-mail over public or private data communications networks including the Internet.

Facsimile Transmission means transactions of a text or graphical nature between two or more persons exchanged via facsimile (FAX) over the Public Switched Telephone Network (PSTN) or other public or private data communications networks including the Internet.

FDA means the federal Food and Drug Administration.

H.320 means the industry-wide compressed audiovideo communication standard from the International Telecommunications Union (ITU) for real time, two-way interactive audiovideo transmission with a minimum signal of 384 kbps (kilobits per second) over a dedicated line; this may include a switched connection.

H.323 means the industry-wide compressed audiovideo communication standard from the International Telecommunications Union (ITU) for real time, two-way interactive audiovideo transmission with a minimum signal of 384 kbps (kilobits per second) over an intranet or other controlled environment system.

Health Care Practitioner means a health care professional who is licensed, certified, or registered with Nebraska Department of Health and Human Services Regulation and Licensure or with the comparable agency in the state in which s/he practices his/her profession.

Health Care Practitioner Facility means the residence, office, or clinic or a practitioner or group of practitioners who are enrolled with Medicaid and credentialed under the Uniform Licensing Law or any distinct part of such residence, office, or clinic.

Legally Authorized Representative means the client's parent if the client is a minor child, a legal guardian, or a person with power of attorney for the client.

T1 Line means a digital transmission service of 1.544 Mbps.

Telehealth means the use of telecommunications technology by a health care practitioner to deliver health care services within his or her scope of practice to a patient located at a site other than the site where the practitioner is located.

Telehealth Service means any contact between a patient and a health care practitioner relating to the health care diagnosis or treatment of such patient through telehealth but does not include a telephone conversation, electronic mail message, or facsimile transmission between a health care practitioner and a patient or a consultation between two health care practitioners.

Telehealth Site means either a health care facility enrolled with Medicaid and licensed under Neb. Rev. Stat. Section 71-2017 to 71-2029, and effective January 1, 2001, licensed under the Health Care Facility Act or a health care practitioner facility whose practitioners are enrolled with Medicaid and credentialed under the Uniform Licensing Law.

Telephone Conversation means a transaction conducted by voice conversations between two or more persons over a private telecommunication system or the Public Switched Telephone Network (PSTN).

Telephone means an instrument for reproducing sounds at a distance; specifically, one in which sound is converted into analog or digital signals for transmission by wire or other modality.

Transmission Cost means the cost of the line charge incurred during the time of the transmission of a telehealth service.

USF means the Universal Services Fund established under the federal Telecommunications Act of 1996.

1-006.03 Standards for Provider Participation:

Health care practitioners must:

1. Act within their scope of practice;
2. Be enrolled with NMAP; and
3. Be appropriately licensed, certified, or registered by the Nebraska HHS Regulation and Licensure agency for the service for which they bill Medicaid. (An exception to this requirement may be allowed when the telehealth service is delivered out-of-state and covered under 471 NAC 1-006.10D Out of State Services.)

Entities enrolled as Medicaid providers other than practitioners (such as hospitals) which bill for practitioner services may bill for telehealth services when the practitioner providing the service meets the above requirements.

In providing telehealth services, health care practitioners and health care facilities shall follow all applicable state and federal laws and regulations governing their practice, including, but not limited to, the requirements for maintaining confidentiality and obtaining informed consent.

Prior to billing Medicaid for any telehealth services, each telehealth site must submit a letter (2 copies) to the Department as required under 471 NAC 1-006.10C regarding quality assurance issues.

1-006.04 Coverage for Telehealth Services and Transmission Costs: Effective July 1, 2000, Medicaid services that are otherwise covered in the NMAP and are provided via telecommunication technologies may be reimbursed under the conditions and limitations set forth in these regulations. Payment for telehealth services must be consistent with the federal requirements of efficiency, economy, and quality. In-person contact between a health care provider and a client is not required under the NMAP telehealth regulations except where otherwise required by federal statute or regulation.

Services otherwise covered by NMAP and delivered via telecommunications technology may be reimbursed when the following conditions are met:

1-006.04A Health Care Practitioner Requirement: Telehealth services are covered only when provided by a health care practitioner meeting the requirements in 471 NAC 1-006.03 Standards for Provider Participation.

1-006.04B NMAP 471 and 482 NAC Requirements: Services provided via telehealth are subject to all current NMAP regulations in 471 and 482 NAC including, but not limited to, the requirement:

1) that services are medically necessary and appropriate to the client's condition;
2) that active treatment for mental health/substance abuse services is met; and
3) that the service provided is a generally accepted standard of care.

1-006.04C Telecommunications Technology: Coverage is only available for telehealth services and for telehealth transmission costs when, at a minimum, the H.320 or H.323 audiovideo standards for real time, two-way interactive audiovisual transmission are met or when any analog or alternate transmission technology system equals or exceeds the H.320 or H.323 standard for clarity and quality. The Department may request an independent expert opinion as to whether a provider's system meets the technology standards for this requirement.

In addition, the telecommunication technology and equipment used at the client site and at the practitioner site must be sufficient to allow the health care practitioner to appropriately evaluate, diagnose, or treat the client or to appropriately accomplish the service billed to Medicaid. At a minimum, the equipment must be of a level of quality to accomplish the level of service and to adequately complete all necessary components as defined in the national standard code sets billed to NMAP.

If a peripheral diagnostic scope or device is required to assess the client, it must provide adequate resolution or audio quality for decision making via telehealth.

Coverage is available for teleradiology services when these services meet the American College of Radiology standards for teleradiology (see ACR Standard for Teleradiology: Revised 1998 (Res.35) Effective 1/1/99 as amended – attached and incorporated by reference).

1-006.04D Prior Authorization: All prior authorization requirements outlined in 471 and 482 NAC for specific services must be met to be covered as a telehealth service. Prior authorization requests must state the intent to provide the service as a telehealth service.

1-006.04E Transmission Costs: Transmission costs for line charges are allowable when directly related to a covered telehealth service and when the standards in 1-006.04C are met for real time, two-way interactive audio visual transmission.

Transmission costs may be covered as outlined in these regulations. However, transmission costs are not a separate billable service and are included in the payment for inpatient hospital services or in the per diem or per monthly payment for the other services below:

1. Inpatient Hospital Services, including general hospital as well as psychiatric and rehabilitation hospital services;
2. Nursing Facility Services;
3. Intermediate Care Facility-Mentally Retarded (ICF-MR) Services;
4. Assisted Living Facility Services;
5. Residential Treatment Center Services;
6. Treatment Group Home Services;
7. Day Treatment Facility Services;

8. Treatment Foster Care Services;
9. Mental Health/Substance Abuse Crisis Facility Services; and
10. Psychiatric Rehabilitative Services.

When a client receives a telehealth service as part of the services listed above, the transmission service must be reported on each individual claim and on the facility's cost report.

1-006.04F Managed Care: Coverage of services delivered via telecommunications technology under contracted Medicaid managed care plans is required to the extent that coverage and reimbursement is available under the Medicaid fee-for-service program. In the event that coverage of services delivered through telehealth proves not to be cost neutral, the appropriate capitation rates may be adjusted.

No fee-for-service coverage outside the managed care plan is available for telehealth services for clients enrolled in managed care.

All managed care referral procedures and authorization requirements shall be followed (see Title 482 NAC).

1-006.05 Non-Covered Telehealth Services: Services provided via telehealth technologies are not covered when any one of the following conditions is met:

1-006.05A Non-Covered Medicaid Services: Services not otherwise covered by Nebraska Medicaid are not covered when delivered via telehealth.

1-006.05B Services Excluded from Coverage as a Telehealth Service: Services covered under other Medicaid regulations but specifically excluded from telehealth coverage are:

1. Medical Equipment and Supplies provided by DME (Durable Medical Equipment) suppliers and pharmacies;
2. Orthotics and Prosthetics provided by DME suppliers and pharmacies;
3. Personal care aide (PCA) services;
4. Home Health Aide Services;
5. Pharmacy services for prescribed drugs;
6. Home and Community Based Waiver services provided by persons who do not meet the standards for a practitioner of telehealth services in 471 NAC 1-006.03;
7. Mental Health, Substance Abuse, and Psychiatric Rehabilitation services provided by persons who do not meet the standards for a practitioner of telehealth services in 471 NAC 1-006.03 (e.g., Community Treatment Aids; Certified Alcohol and Drug Abuse Counselors; Ph. D. candidates who are not licensed or certified; and other enrolled professionals who are not licensed, certified, or registered by HHS – Regulation and Licensure);
8. Medical Transportation services, including ambulance services;
9. Federal Qualified Health Center core services billed as an "encounter" service;

10. Rural Health Clinic core services billed as an “encounter” service;
11. Physician visits to clients in nursing facilities required on the specified periodic schedule for nursing facility certification;
12. Tribal 638 Clinic core services billed as an “encounter” service;
13. Services requiring “hands on” professional services such as eye glass fittings and hearing aid fittings;
14. Services provided in public schools by staff who are not licensed, certified, or registered with HHS – Regulation and Licensure;
15. Ambulatory Room and Board services; and
16. Other services that do not meet the requirements of these telehealth regulations.

1-006.05C Inappropriate Telecommunications Technologies: Coverage is not available when the minimum standards for telecommunication technologies in 471 NAC 1-006.04C are not met or when the technologies used are not appropriate for the service delivered and billed to Medicaid.

1-006.D Free to the General Public: Medicaid does not reimburse services that are provided free to the general public. See 471 NAC 3-001.02D and 2-001.03(1 through 5).

1-006.05E Distance Requirement: Services provided via telecommunications technologies are not covered if the client has access to a comparable service within 30 miles of his/her place of residence. This requirement does not apply:

1. In emergency or urgent medical situations;
2. When accessing the appropriate service at a distance less than 30 miles poses a significant hardship on the client due to a medical condition or disability; or
3. To clients residing in nursing facilities who require transportation to the appropriate service via ambulance.

When billing a telehealth service or transmission cost within a 30 mile radius of the client’s place of residence, one of the above three reasons must be documented in the medical record and available to the Department upon request.

1-006.05F E-Mail, Telephone, and Facsimile Transmissions: Telehealth services provided via e-mail, telephone, or facsimile transmissions are not covered.

1-006.05G Devices Subject to FDA Approval: Medicaid does not cover services that utilize a device or telecommunication technology subject to FDA approval but not FDA approved for the telehealth service. However, FDA approval does not guarantee coverage of a service.

1-006.05H Prescriptions over the Internet: Neither the prescribing health care practitioner service nor the pharmacy service is covered when the health care practitioner prescribing the medication has only reviewed an e-mail message or e-mail questionnaire about the client.

1-006.05I Investigational/Experimental Services: A telehealth service is not covered when the service delivered via telecommunication technology is deemed to be investigational or experimental under 471 NAC 1-002.02C. Even though a service is covered when provided in-person to a client, the service may be deemed investigational/experimental for Medicaid payment purposes when provided via telecommunications technology. (Also, see 471 NAC 1-006.05G regarding devices requiring FDA approval.)

An example of a service excluded from telehealth coverage because the services are deemed investigational/experimental or do not meet current accepted standards of medical care is as follows: surgery performed by a mechanical device operated by a practitioner who is at a site different from where the patient is located.

1-006.05J Services Requiring Direct Physical Contact with a Practitioner: Services that require direct physical contact with a client by a health care practitioner and that cannot be delegated to another health care practitioner at the site where the client is located are not covered.

1-006.06 Non-Covered Transmission Costs

1-006.06A Low Transmission Capacity: Transmission costs are not covered when the real time, two-way interactive audio-visual transmission is below the standards stated in 471 NAC 1-006.04C; for example, transmission has a signal less than 384 kbps.

1-006.06B Negligible Transmission Time: Transmission costs are not covered when transmission time is negligible. Transmission time is negligible in instances such as, but not limited to, the store and forward transmission of data sent for professional review and interpretation. Transmission time less than 5 minutes for a telehealth service is deemed negligible for Medicaid payment purposes under this section.

1-006.06D Medicare/Insurance Covered Telehealth Service: Providers shall not bill Medicaid or the client for transmission costs incurred as part of a Medicare covered telehealth service and excluded from Medicare coverage. If the practitioner bills insurance or other third party liability entity for the telehealth service, and payment for the telehealth service includes payment for transmission costs, the provider shall not bill Medicaid separately for transmission costs.

1-006.06E Non-Covered Telehealth Services: Transmission costs are not covered when the telehealth service provided by the health care practitioner is not covered under these regulations.

1-006.07 Rural Health Clinic and Federally Qualified Health Center Encounter Rates: Telehealth services are not covered under the encounter rate for rural health clinic (RHC) core services and federally qualified health center (FQHC) core services where reimbursement is based on a "face to face" encounter between a provider and a patient. See 42 CFR 405.2463 (a) (1) and (2); 447.371 (d); and 440.20 (b) (1) and (2). See 471 NAC 29-003.01.

Telehealth services provided by a RHC or FQHC may be covered at a fee-for-service rate per the telehealth regulations using non-RHC and non-FQHC core service provider numbers.

1-006.08 Tribal 638 Clinic Services: Telehealth services are not covered under the reimbursement for core services billed under an encounter rate. Telehealth services provided by Tribal 638 Clinics may be covered under these telehealth regulations for other services billed at the fee-for-service rates.

1-006.09 Nursing Facility Periodic Physician Visits: Telehealth coverage is not available for physician visits to clients in nursing facilities (NF) required on the periodic schedule of at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. This periodic schedule of visits is required for nursing facility certification under regulations that require that a client "be seen" by the physician. See 471 NAC 12-007.09 and 42 CFR 483.40 (c) (1).

1-006.10 Other Requirements and Limitations for Telehealth Services

1-006.10A Informed Consent: Before an initial telehealth service, the practitioner who delivers the service to a client shall ensure that the following written information is provided to the client in a form and manner which the client can understand, using reasonable accommodations when necessary, that:

1. S/he retains the option to refuse the telehealth service at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the client would otherwise be entitled;
2. Alternative options are available, including in-person services, and these options are specifically listed on the client's informed consent statement;
3. All existing confidentiality protections apply to the telehealth consultation;
4. S/he has access to all medical information resulting from the telehealth consultation as provided by law for patient access to his/her medical records;
5. The dissemination of any client identifiable images or information from the telehealth consultation to anyone, including researchers, will not occur without the written consent of the client;
6. S/he has a right to be informed of the parties who will be present at each end of the telehealth consultation and s/he has the right to exclude anyone from either site; and

7. S/he has a right to see an appropriately trained staff or employee in-person immediately after the telehealth consultation if an urgent need arises, or to be informed ahead of time that this is not available as provided in 471 NAC 1-006.10B Support at Client Site.

The health care practitioner shall ensure that the client's informed consent has been obtained before providing the initial service. The client's signature indicates that s/he understands the information, has discussed this information with the health care practitioner or his/her designee, and understands the informed consent may apply to follow-up telehealth services with the same practitioner. The health care practitioner providing the telehealth service or staff at the client site shall retain the signed statement, and the statement must become a part of the client's medical record. A copy of the signed informed consent must also be given to the client.

If the client is a minor or is incapacitated or is mentally incompetent such that s/he is unable to sign the statement, the client's legally authorized representative shall sign the informed consent statement to give consent. The health care practitioner providing the telehealth service or staff at the client site shall retain the signed statement, and the statement must become a part of the client's medical record. A copy of the signed informed consent must also be given to the client's legally authorized representative.

The requirement to obtain written informed consent before providing a service does not apply in emergency situations where the client is unable to sign the written statement as required above and the client's legally authorized representative is unavailable. However, within 72 hours after the telehealth service is provided, the health care practitioner shall obtain the signature of the client or his/her legally authorized representative on the informed consent form indicating s/he has been informed that a telehealth service was delivered and all the written statements in the informed consent statement apply. The health care practitioner providing the telehealth service or staff at the client site shall retain the signed statement, and the statement shall become a part of the client's medical record. A copy of the signed informed consent must also be given to the client or to the client's legally authorized representative.

A sample informed consent statement is available from the Department upon request. (See suggested form in 471-00-10 of the appendix)

1-006.10B Support at Client Site: An appropriately trained staff or employee familiar with the client's treatment plan or familiar to the client must be immediately available in-person to the client receiving a telehealth service to attend to any urgencies or emergencies that may occur during the service. "Immediately available" means the staff or employee must be either in the room or in the area outside the telehealth room in easy access for the client. This requirement may be waived on an individual client basis for repetitive services when documentation shows that a safe routine has been established for the client, such as for a home health service, and that the client has consented to this exception. The health care practitioner providing the telehealth service shall document this fact in the medical record, with the rationale as to why an appropriately trained staff or employee need not be immediately available.

1-006.10C Quality Assurance Requirements: Each telehealth site shall have established written quality of care protocols and patient confidentiality guidelines to ensure telehealth services meet the requirements of state and federal laws and established professional patient care standards. Prior to initial billing for telehealth services, each telehealth site shall submit two copies of a letter to the Department, addressed to the Medicaid Medical Director:

1. Certifying written quality of care protocols are operational at the sites where telehealth services are provided;
2. Certifying written patient confidentiality protocols are operational at the sites where telehealth services are provided;
3. Listing the facility provider number, the names of all health care practitioners providing telehealth services and their Medicaid provider identification numbers, and the services provided at that site;
4. Naming an authorized contact person with his/her phone number;
5. Documenting that the telehealth technologies meets the standards in 471 NAC 1-006.04C, and
6. Attaching a sample copy of the provider's informed consent form (see 471 NAC 1-006.10A).

The provider shall make the protocols and guidelines available for inspection at the telehealth site and to the Department upon request. The provider shall send any changes to the written submitted information to the Department in writing prior to billing under the changes. (Also see 471 NAC 1-006.10F, Medical Records; and 1-006.10G, Confidentiality and Integrity of Data.)

1-006.10D Out-of-State Services: Under 42 CFR 431.52 and 471 NAC 1-002.02G, Nebraska Medicaid covers telehealth services furnished in another state to the same extent it would pay for telehealth services furnished in Nebraska if the services are furnished to a client who is a resident of Nebraska but who is physically located in another state at the time the service is delivered, and any of the following conditions are met:

1. Medical services are needed because of a medical emergency;
2. Medical services are needed and the client's health would be endangered if s/he were required to travel to his/her state of residence;
3. The Department determines, on the basis of medical advice, the needed medical services, or necessary supplementary resources, are more readily available in the other state; or
4. It is general practice for clients in a particular locality to use medical resources in another state.

The practitioner providing the telehealth service to a Nebraska Medicaid client while the client is physically located in another state must meet the requirements for provider participation in 471 NAC 1-006.03 except for item 3. Instead of item 3, the practitioner must be appropriately licensed, certified, or registered by the state agency in that state for the service billed to Nebraska Medicaid.

All prior authorization requirements for out-of-state services must be met.

1-006.10E Requirements for Services to Medicaid Eligible Persons with Other Health Care Coverage:

1-006.10E1 Medicare/Medicaid Eligible Clients: All Medicare-covered services must first be billed to Medicare. Medicaid does not cover services denied by Medicare for lack of medical necessity. Medicaid pays only coinsurance and deductibles for Medicare-covered services. No additional payments will be made for transmission costs for Medicare-covered services.

1-006.10E2 Clients with Other Health Care Coverage: Because Medicaid is the payer of last resort, services must first be billed to other liable third party payers. When a service is covered by a third party payer and includes the transmission costs, Medicaid will not make an additional payment for the transmission costs.

1-006.10F Medical Records: The practitioner shall keep a complete medical record on all telehealth services provided to clients, following all applicable statutes and regulations for medical record keeping and confidentiality. The use of telehealth technology must be appropriately documented in the medical record, including the treatment plan, progress notes, and treatment plan reviews.

In addition, the medical record must include the following:

1. A full notation describing the health care service delivered via telecommunication technology and indicating which site initiated the call;
2. A list of the telehealth technologies used for the service (e.g., real-time two-way interactive audio-visual transmission via a T1 line; digitalized radiology transmission via store and forward technology; electronic stethoscope; etc.);

3. Documentation showing the time the service began and ended;
4. When applicable, a notation by the practitioner that a copy of the required signed telehealth informed consent statement is in the client's record at the site where the client is physically located (see 471 NAC 1-006.10A Informed Consent);
5. Documentation in the medical record supporting the need for the level of care delivered via telehealth, and
6. When applicable, reasons for an exception to the 30-mile distance requirement (see 471 NAC 1-006.05E).

1-006.10G Confidentiality and Integrity of the Data: All confidentiality laws and other requirements that apply to written medical records shall apply to electronic medical records, including the actual transmission of the service and any recordings made during the time of the transmission.

All transmissions must be performed on a dedicated secure line or must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission information. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.

Providers of telehealth services shall implement confidentiality protocols that include, but are not limited to:

1. specifying the individuals who have access to electronic records;
2. usage of unique passwords or identifiers for each employee or other person with access to the client records;
3. ensuring a system to prevent unauthorized access, particularly via the internet or intranet; and
4. ensuring a system to routinely track and permanently record access to such electronic medical information.

1-006.11 Payment Methodology: The Nebraska Medical Assistance Program (NMAP) pays for covered telehealth services and transmission costs as follows:

1-006.11A Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

1-006.11B Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of:

1. The provider's submitted charge; or

2. The maximum allowable amount. (See the appropriate Nebraska Medicaid Practitioner Fee Schedule in effect for the date of service.)

The Medicaid maximum allowable is determined by using the highest USF subsidized monthly rate in Nebraska for transmission up to a T1 line, assuming an 8 hour per day/5 days per week usage to determine a per minute unit reimbursement. The Medicaid maximum allowable rate for transmission costs may be reviewed periodically by the Department.

1-006.12 Billing Requirements: Providers of telehealth services shall bill Medicaid for services provided via telecommunication technology according to the Medicaid requirements and claim submission instructions for the service type.

Only the provider incurring the cost of a transmission shall bill for the telehealth transmission cost. Providers shall bill transmission costs at the rate charged the general public. Providers shall bill the transmission costs for the actual length of time of the transmission of the telehealth service.

Reimbursement is not available for stand-by time when the sites are in contact but either the patient or the provider is not available for the service.